

**Regina D. Morrow Ed.S., LMFT, LMHC, NCC**  
104 West 6<sup>th</sup> Avenue Windermere, FL 34786  
(407) 876-2078 office (407) 876-7378 fax [Reg@cfl.rr.com](mailto:Reg@cfl.rr.com)

## **Authorization Form: Regina to Other**

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

Client name \_\_\_\_\_ Date \_\_\_\_\_

D.O.B. \_\_\_\_\_

Home Phone \_\_\_\_\_ Work or cell phone\_\_\_\_\_

I authorize my therapist: Regina D. Morrow Ed.S., LMFT, LMHC, NCC  
104 West 6<sup>th</sup> Avenue Windermere, Fl 34786  
(407)876-2078 office (407) 876-7378 fax

(407)373-2078 voice (407) 373-1578 fax

This information should only be released to (name of person to whom the information is to be released)

Name of person or organization

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## Address

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## Address

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## Phone

Fax

I am requesting my therapist to release this information for the following reasons:

This authorization shall remain in effect until (expiration date) or until (an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

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**Signature of Patient**

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Date

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**Signature of Parent or Guardian**

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Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.